ISD System Proposal

SSR Number(s): 2003-0615-02
SSR Title: Outpatient Pricing Change
Requester(s) Name: Cecilia Fruitman
Requester(s) Phone: X74233
Subsystem(s): Claims
Date Scheduled for Release: 7/1/2005
Prepared By: Mark Renkel
Date Prepared:
ISD Project Manager: Mike Upchurch

Version #	Date
001	10/28/2004

Table of Contents

SSR Number(s): **2003-0615-02**

SSR Title: **Outpatient Pricing Change**

1 Signatures (Required)

ISD Representative who prepared the document

Name: Mark Renkel
(Please Print)

Signature: _____ Date: _____

ISD Project Manager who reviewed/approved the document

Name: Mike Upchurch
(Please Print)

Signature: _____ Date: _____

AHCCCS (Arizona) User Representative who reviewed/approved the document

Name: Cia Fruitman Implementing:
(Please Print) Yes: ☐ No: ☐

Signature: _____ Date: _____

AHCCCS (Arizona) User Representative who reviewed/approved the document

Name: Sara Harper Implementing:
(Please Print) Yes: ☐ No: ☐

Signature: _____ Date: _____

AHCCCS (Arizona) User Representative who reviewed/approved the document

Name: Sue Carter Implementing:
(Please Print) Yes: ☐ No: ☐

Signature: _____ Date: _____

AHCCCS (Arizona) User Representative who reviewed/approved the document

Name: Rebecca Fields Implementing:
(Please Print) Yes: ☐ No: ☐

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MED-QUEST (Hawaii) User Representative who reviewed/approved the document

Name: N/A Implementing:
(Please Print) Yes: ☐ No: ☐

Signature: _____ Date: _____

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ISD Testing Representative who reviewed/approved the document

Name: Lori Petre
(Please Print)

Signature: _____ Date: _____

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2 Signatures (If Applicable)

ISD Operations Representative who reviewed/accepted the document

Name: _____
(Please Print)

Signature: _____ Date: _____

ISD Database Representative who reviewed/accepted the document

Name: _____
(Please Print)

Signature: _____ Date: _____

ISD Network Services Representative who reviewed/accepted the document

Name: _____
(Please Print)

Signature: _____ Date: _____

ISD Security Representative who reviewed/accepted the document

Name: _____
(Please Print)

Signature: _____ Date: _____

Title:

Name: _____
(Please Print)

Signature: _____ Date: _____

Title:

Name: _____
(Please Print)

Signature: _____ Date: _____

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3 Change Management

(REQUIRED for all Approved Change Requests)

Request #	Date Change Approved	Requested By	Reason	User Approving Authority

4 Objective & Scope

Replace the existing outpatient pricing methodology with new capped fee schedule rates based on CPT/HCPCS procedure codes, hospital cost-to-charge ratios, peer group adjustments and other factors. This will apply to acute in-State non-IHS hospitals for dates of service beginning 7/1/2005.

5 Roles & Responsibilities

(REQUIRED - If applicable)

User: Define, document, and communicate Encounter and Claims processing policy.

ISD: Develop technical solutions to implement the policy within PMMIS.

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6 Impacts & Critical Dates

(REQUIRED - If applicable)

6.1 Business & System Impacts

Programs:

- CLED4550 Claims Duplicate Check
- CLPR2150 Claims non-Tier Service Limits
- CLPR2450 Claims Form 1500 Valuation
- CLPR2750 Claims Form UB-92 non-Tier Valuation
- CLPV0130 Claims Rate Schedule Lookup

Edit Updates:

Table Updates:

- CL101 Claim Edits
- CL102 Edit Type – Edit
- CL103 Edit Type – Valid Result
- CL112 Edit Response Worksheet

6.2 Critical Dates

See Section 8 – Schedules and Milestones.

7 Detailed Design

(REQUIRED)

Claim Pricing (Program CLPR2750)

OPFS Pricing Loop

Loop through the claim lines testing each procedure code against RF797 (bundle drivers)

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If the procedure code matches

Loop through the remaining claim lines testing each revenue code against RF796 (bundled revenue codes)

If the revenue code matches

Set the allowed amount to zero

If the revenue code does not match

Test the procedure code against RF126 (new outpatient rate schedule)

If the procedure code matches

Set the allowed amount to units * RF126 rate

If a rate is not found

Set the allowed amount to billed amount * RF618 SCO rate

If the procedure code does not match

Set the allowed amount to units * RF126 rate

If a rate is not found

Set the allowed amount to billed amount * RF618 SCO rate

For any lines priced using RF126 that were billed with modifiers

Adjust the allowed amount using the RF122 rate

For any lines priced using RF126

Adjust the allowed amount using the PR050 peer group multiplier

Perform multiple surgery discounting

If the surgical procedure if not found on the RF789 surgical exception table, discount secondary surgeries 50% when they are not billed with an appropriate discounting modifier

Rate Schedule Lookup (Program CLPV0130)

If the incoming rate schedule parameter is 'OPF'

Look up the procedure code rate on RF126 (clone existing procedure

GET-HCPCS-PRC)

Critical Claim Edits

- Verify the bill type (values 100-148 and 85x for outpatient, inpatient and critical access hospitals).
- Verify the submitted revenue code and procedure code values (RF110, RF706).

- Verify that the procedure code is present when required for the revenue code (RF774).
- Verify that the combination of revenue code, procedure code, and procedure modifier are valid (RF773, RF122).
- Verify that the services are covered (RF123).
- Verify that service limits are not exceeded (RF127).
- Enable modifier logic for UB92's.
- Review existing 1500 edits and determine which are appropriate for UB editing.

Correct Coding

RF128 is a new table that will identify codes that cannot be concurrently billed.

If a billed procedure code pair is found on RF128, that line will be denied.

If the billed procedure code is a bundled driver, the claim will be denied.

Multiple Surgeries (Programs CLPR2450, CLPR2750)

Surgical procedures with a Payment Status Indicator of 'S' or 'T' will not be discounted by the system, or procedures on the surgical exception table.

Claims Service Limits (Program CLPR2150)

There is a procedure modifier matrix from Ingenix in the Attachments section. These values need to be incorporated into service limit processing. A new reference table will contain codes which affect service limits and duplicate check.

RF127 Frequency Service Limits

When the frequency parameter is Month or Year, the current service limit periods are calendar based, i.e. the month/year(s) including and between the service begin and end dates.

These should be based instead on a span of days, 31 days per month and 365 days per year. In the case of a 1 month service limit period, the calculated dates would be the service begin date minus 30 days and the service end date plus 30 days. All paid units for the procedure intersecting either period would be accumulated, and the claim's billed units added to the totals for each period. The period totals would then be compared to the maximum allowed units for the period. Excess billed units would be subject to system cutback.

Converting the Month and Year parameters to a span of days would align the RF112 frequency service limit processing with Encounter Form 1500 audit program EC93L932.

Late Charges

Outpatient Late Charge claims (Bill Type 135) will not be paid. Void and resubmit the original claim.

Duplicate Check (Programs CLED4550, CLSF4706)

The existing Outpatient to Outpatient duplicate check uses the following matching criteria at the claim header level:

- Form Type
- AHCCCS Id (or alias)
- Service Provider (or alias)
- Dates of Service
- Admit Hour

The use of Admit Hour will be discontinued. Instead, the duplicate check will be bypassed if Condition Code 'G0' (Distinct Medical Visit) is billed.

Procedure code will be added to the Outpatient to 1500 duplicate check. Procedure codes billed with modifier '25', '27', '59', '76', or '77' will not be considered duplicates.

New User Reports

By Hospital:

- Claims missing units or units in excess of service limits.
- Invalid combinations of revenue code, procedure code, and/or procedure modifier.

8 Schedules & Milestones

Milestones	Lead	Begin	Complete	Status
Requirements to ISD for PMMIS changes.	DHCM		6/15/2004	Completed
Requirements Draft	ISD		4/15/2004	Completed
Requirements Final	ISD		7/1/2004	Completed
System Proposal/Design Draft	ISD		3 weeks from Requirement Final	Completed
System Proposal/Design Final	ISD		2 weeks from System Proposal Draft	In Progress Final to be distributed to Health Plans/Program Contractors for review by 11/5/2004
Project "Workgroup" Meetings				
Health Plans/Program Contactors	DHCM, ISD	4/21/2004		Completed
Health Plans/Program Contactors	DHCM, ISD	5/12/2004		Completed
Health Plans/Program Contactors	DHCM, ISD	6/2/2004		Completed

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Health Plans/Program Contactors	DHCM, ISD	6/23/2004		Completed
Health Plans/Program Contactors	DHCM, ISD	7/14/2004		Cancelled
Health Plans/Program Contactors	DHCM, ISD	8/4/2004		Cancelled
Health Plans/Program Contactors	DHCM, ISD	8/31/2004		Completed – Rescheduled from 8/25
Health Plans/Program Contactors	DHCM, ISD	9/15/2004		Cancelled
Health Plans/Program Contactors	DHCM, ISD	10/05/2004		Completed
Health Plans/Program Contactors	DHCM, ISD	11/09/2004		
Health Plans/Program Contactors	DHCM, ISD	12/09/2004		
2005 Meetings	DHCM, ISD	TBD		
Develop OPPS Workgroup Email Address and Issues Tracking Processes	ISD, DHCM	4/12/2004	5/4/2004	Completed
System Development	ISD	Immediately following finalization of System Proposal/Design	90 days	
System/Integration Testing	ISD	Immediately following completion of System	60 days	

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		Development		
Pilot Testing w/ Hospital Trading Partners	ISD, DHCM	2/1/2005	2/28/2005	
Pilot Testing w/ Health Plan/Program Contractor Trading Partners	ISD, DHCM	2/1/2005	2/28/2005	
User Acceptance Testing	DHCM, DFFS	3/1/2005	5/31/2005	
Trading Partner Testing w/ Hospitals	ISD, DHCM	3/1/2005	6/30/2005	
Trading Partner Testing w/ Health Plan/Program Contractors	ISD, DHCM	3/1/2005	6/30/2005	
Verify all table, provider rate file updates	ISD, DFSM		5/31/2005	
Implementation of Table Changes	ISD		6/1/2005	
Implementation all Remaining Components	ISD		7/1/2005	

10 Assumptions

(REQUIRED - If applicable)

- Modifier amount pricing, currently used for anesthesia and DME, will not apply to OPFS pricing.
- Multiple surgery and correct coding changes for form 1500 will be addressed by a separate SSR.
- The following HIPAA-related changes will be addressed by a separate SSR:
  - The system will be able to process 999 UB-92 lines.
  - The system will be able to process 4 digit revenue codes.
  - The system will be able to all formats of procedure codes.

11 Attachments

(REQUIRED - If applicable)

Critical Claim Edit Matrix

Edit	Description	Table
New	Bill Type must be 100-147 or 85x. (Currently, RF774 validates the Revenue Code/Bill Type relationship, and RF618 is used for Revenue Code to Provider Type.)	RF774 RF618
H078	Verify Bill Type	RF706
L001	Verify Procedure Code	RF110
L040	Verify a Procedure Code is present when required for the Revenue Code	RF774
L040	Validate the Revenue Code to Procedure Code relationship	RF773
L060/L061	Verify the Procedure Code Modifier	RF114
L112/L113	Validate the Procedure Code to Modifier relationship	RF122
L013	Verify Procedure Code Coverage	RF123
New	Verify Outpatient Procedure Service Limits are not	RF127

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	exceeded	
New	Verify Correct Procedure Code Coding	RF128

Procedure modifiers that bypass multiple surgery discounting.

Modifier	Description	Remarks/Action
25	Separately identifiable E & M service.	Pays E & M in addition to diagnostic or surgical procedure of the same date
27	Multiple E & M same date	Pays additional E & M service same date
59	Separately identifiable procedure	To report services that are not normally reported together. Currently, 59 sends claims to Med review
76	Procedure/service repeated in a separate operative session on the same day	Will need to over-ride daily limit/dupe edits
77	Repeat procedure/service, another physician, same day	Will need to over-ride daily limit/dupe edits

12 Addendum

(REQUIRED - If applicable)

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